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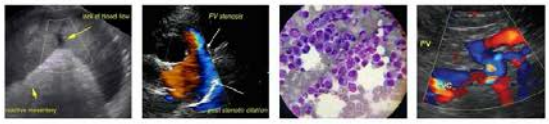

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Cody Merola

SPECIES

Canine

BREED

Retriever X

SEX

Neutered Male

AGE

10 Years 6 Months

WEIGHT

66 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Dr. Greg H

INVOICE

25003

DATE

8/27/21

PRESENTING CLINICAL SIGNS

rectal exam revealed ~1 cm firm nodule in left anal gland.PU/PD and hind limb weakness over the last 2 weeks. Patient had a CBC/chem/UA with previous vet that revealed elevated calcium, decreased phosphorus, and low urine specific gravity. Appetite has been decreased during this span and is now mostly eating chicken. Has had chronic hind end weakness/pain since he was ~3 yrs old. No C/S/V/D. Has had lip fold dermatitis that waxes and wanes. No other historical problems/current medications reported, except flea/tick/heartworm prevention. Objective Vitals: 12:03pm 8/27/21 Wt: 66 lb. 4.8 oz. T: 100.8 F. HR: 150 RR: pant CRT: PK/1 By: GH General Appearance: Bright, alert, responsive; pink MM; CRT <2 sec; body condition score=6/9; hydrated; left submandibular salivary gland enlargement Eyes: No corneal lesions bilaterally; pupils normal in size and symmetrical; no conjunctivitis; no ocular discharge Ears: AU no exudate observed; no erythema present Integument: Moderate bilateral manibular lip fold dermatitis and very mild left nostril crusting consistent with mucocutaneous pyoderma Oral Cavity: Moderate tartar Lymphatics: Lymph nodes all normal size Cardiovascular: Regular rhythm; no murmur detected; strong femoral pulses Musculoskeletal: Moderate difficulty rising with moderately thickened bilateral stifles and associated thigh/gluteal atrophy Gastrointestinal: Benign abdomen on palpation; rectal exam revealed ~1 cm firm nodule in left anal gland Urogenital: External genitalia appears normal; bladder normal on palpation Respiratory: Lungs auscult clear; no tachypnea or dyspnea; no tracheal sensitivity Neurologic: Bilateral pelvic limb absent CPs with intact pain and motor
Abnormal PE/Chem/CBC/UA Results: CA 14.6, Phos 2.0, Mg 1.3 Chest rads confirm pleural effusion

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.55 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.77 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.41 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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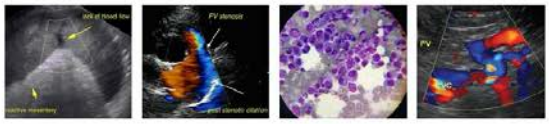

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Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a very small ill-defined, hypoechoic nodule seen in the middle of the splenic parenchyma at 0.54 cm.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

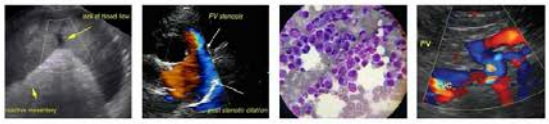
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

Scant anechoic pleural effusion visualized.

ULTRASONOGRAPHIC FINDINGS

- Mildly mottled spleen with subtle hypoechoic nodule – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.



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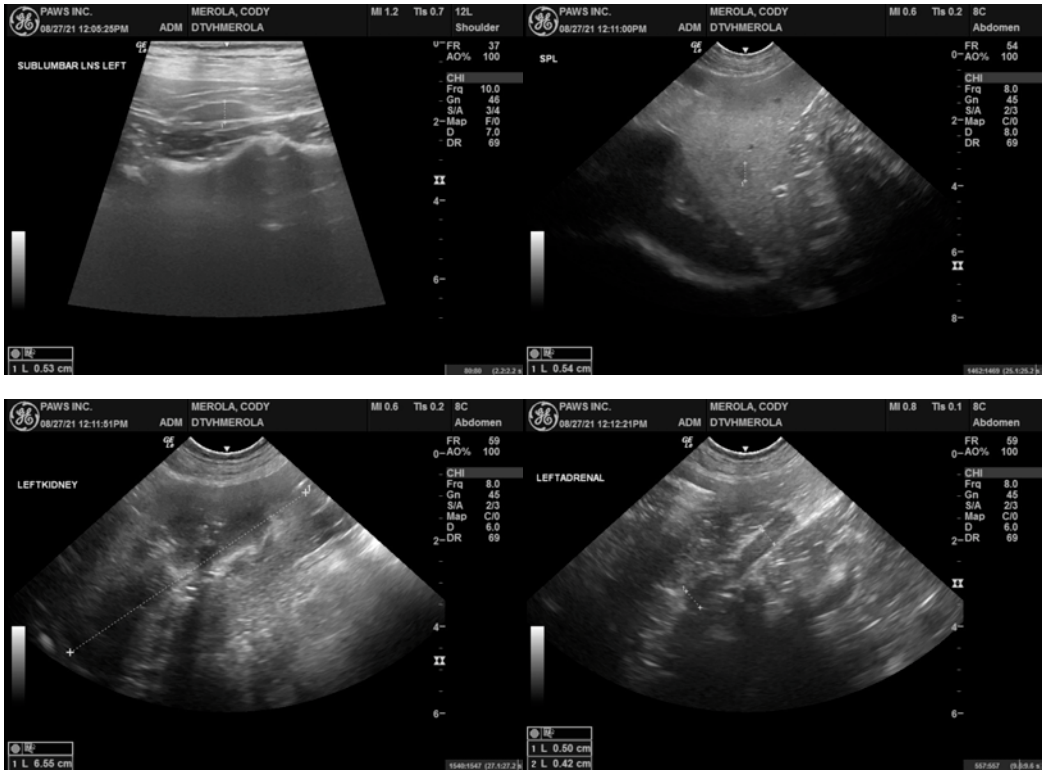
- Scant pleural effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious abdominal lesion was not observed, which could explain the pleural effusion noted. The history of hypercalcemia and the anal gland mass are highly suspicious for a diagnosis of anal gland carcinoma. You could consier fine needle aspirate of the anal gland or removal with histopathology. Consider a hypercalcemia malignancy panel for an ionized calcium, PTH, and PTHrP level, and if able, sampling of the pleural effusion for cytologic analysis. It is not clear at this time if the pleural effusion is related to the anal gland mass. I did not see any evidence of significant lymphadenopathy or metastasis in the abdomen, which would be the most likely first location this tumor would metastasize to. Correlate these findings wth blood work, full body radiographs, etc.

You could consider a fine needle aspirate of the spleen, but I think it is unlikely that you will reach the small nodule noted.



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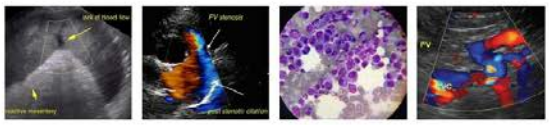

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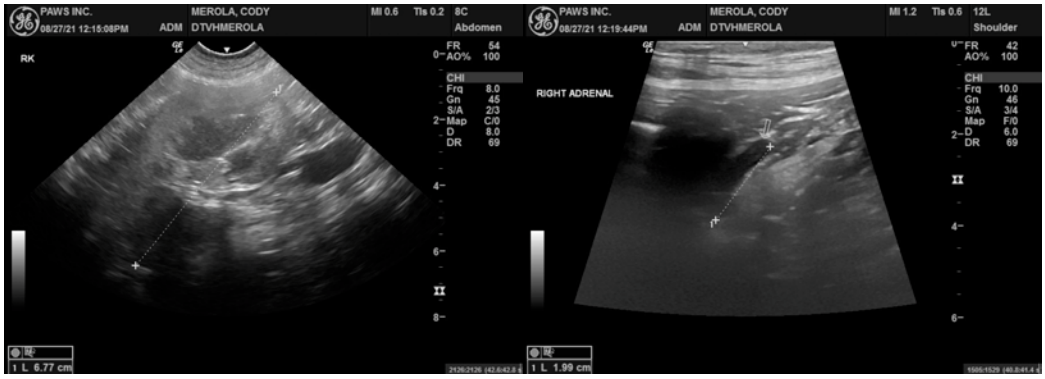

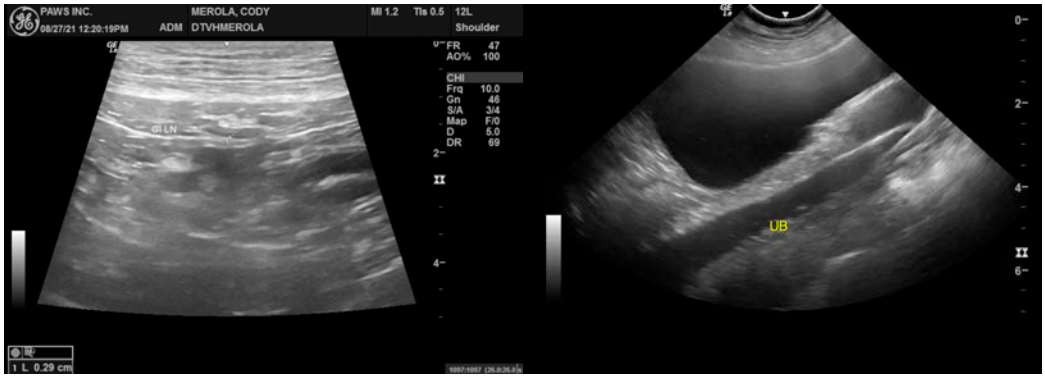

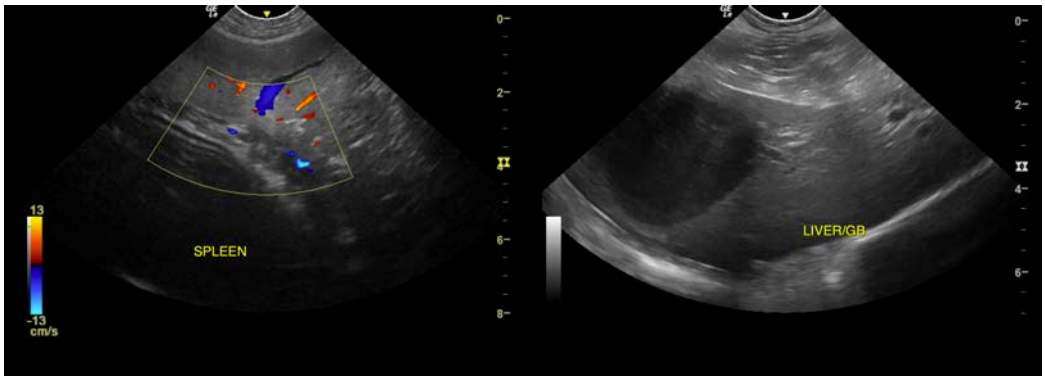

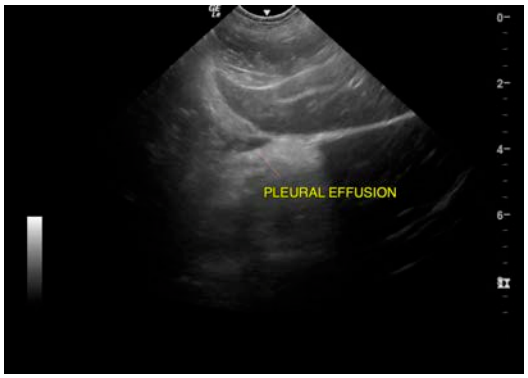

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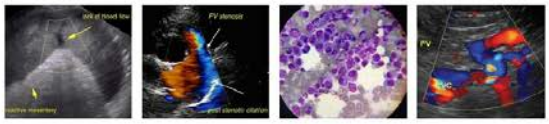

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com